Employee Handbook For Joint Commission Sustainment

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EVANS ARMY COMMUNITY HOSPITAL
FORT CARSON, CO
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The purpose of this guide is to provide you with additional education about regulatory standards and how EACH meets such standards by continually improving care, treatment, and services.

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For questions about Joint Commission standards please contact:
Ms. Christine Levy, The Joint Commission Sustainment Office (TJCSO) Officer.... 526-7923
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Chief, Quality Support Division.... 526-7727

To access the 2011 Joint Commission Standards, please visit, https://amp.jcrinc.com/ProxyLogin.aspx?lnk=F13578C20A61 any staff member can access the Joint Commission CAMH found there. Evans Army Community Hospital (EACH) is accredited by The Joint Commission (TJC). As such, any individual who provides care, treatment, and services can report concerns about safety or the quality of care to TJC without retaliatory action from the hospital. If you have any concerns that have not been addressed by EACH, please contact TJC at 1-800-994-6610.

Questions that cannot be answered by TJCS Officer will be sent to the appropriate deputy, Subject Matter Expert (SME), or the Standards Interpretation Group (SIG) at the Joint Commission.

EVANS ARMY COMMUNITY HOSPITAL MISSION, VISION, AND VALUES:

Our Mission: To deliver on the promise and partnership of quality, safe, and valued Warrior and Family centered care.

Our Vision: The MEDCOM's premier health care team of choice.

Our Values:

Loyalty…	to the MEDDAC, the Army and our beneficiaries
Duty…	working hard each day to meet our mission
Respect…	for one another and those we serve
Selfless Service…	putting our patients and others before ourselves
Honor…	living up to all the Army values
Integrity…	knowing and doing what is right
Personal Courage…	to lead and accept change in uncertain times

Our Motto: *Care With Honor!*

FREQUENTLY ASKED QUESTIONS/SURVEY TIPS

What do you do if a person approaches you and tells you that they are a Joint Commission Surveyor and they are not accompanied by one of our staff nor do they have on an EACH ID Badge?

- Ask them for their official Joint Commission Badge containing their picture and hologram.
- Contact the Chief of Security or AOD after duty hours and tell them that there is a surveyor in the building and then take that individual(s) to either the Security Office or AOD.
- The Security Officer or AOD is then responsible for notifying TJCSO and the Command Suite that a surveyor is in the building.

Individuals whose surveyor status cannot be validated will be escorted from the building.

How will you know that we are undergoing a survey? DoD MTFs are notified that they will be surveyed 7 days prior to a survey. A message will be sent out on EACH ALL as soon as notification arrives.

Know your job and your department.

- Always have your badge on and visible (above the waist).
- Know your own scope of responsibility; know your department's PI projects or success stories.
- Know your fire zone, emergency management responsibilities, MSDS book location, SOPs (make sure they are current and reflect what you actually do)
- Make sure that patient privacy is maintained (records are secured and privacy is maintained in clinic areas).
- If you don't know an answer, don't make one up. Just say, "I don't know, but I can ask my supervisor, or I know where to go to find the answer." Remember that many "answers" may be hanging from your badge; and you can look at it.
- Know the Joint Commission standards that apply to your area and if questioned about a standard that you don't understand, ask the surveyor to explain it. **Do NOT** make up an answer if you are unsure.

Clinical Issues: Informed consent must be obtained prior to the administration of blood or blood products. If the patient is too unstable, counseling of a family member or the fact that the patient was too unstable to obtain consent, should be documented in the Progress Notes.

AR 40-66 Medical Record Administration and Healthcare Documentation and the Medical Staff Bylaws (MEDDAC Reg. 40-9) require verbal orders to be signed within 24 hours. The physician must **date**, **time**, and **sign** a verbal order to ensure compliance with regulations.

Environment of Care and Administrative Issues:

- Monthly fire extinguisher checks should be completed and documented.
- The work area/clinic/ward should be clean and orderly. Nothing is to be taped or tacked to walls, windows and other surfaces.
- Remove all old tape, grease and grime from patient areas and staff work centers.
- Bulletin board information should be current and professional and hallway bulletin boards in patient areas should be enclosed in glass.
- The current Commander's signature should be on all displayed memorandums.
- SOP books should be current.

- ❖ Every inpatient area should have a staffing plan, which defines adequate staffing and describes how an area gathers performance data to evaluate the staffing plan.

- ❖ Information on Advanced Directives, Patient Rights and applicable patient education should be available

If the surveyors find a missing policy or procedure, volunteer to find/fix it while they are here.

What do you do with expired medications? They get returned to the pharmacy according to MEDDAC Reg 40-2-114. Check your area frequently for expired medications.

They will ask your patients if you have explained everything to them. Make sure you explain their illness, their medications and expected results from the medication, discharge instructions, and create a positive and informative experience for the patient. The patient's **perception of their care** is the key here.

Do not mix sterile and non sterile items in storage rooms.

What are TRACERs? Tracers are the foundation of how we sustain compliance with the standards. Tracer Methodology is the process by which surveyors evaluate a facility. In a Tracer, a surveyor selects a patient, reviews the chart and "traces" the areas where that patient received care. This process during a survey can last 1-3 hours, but we have Tracer Teams who replicate this process throughout the hospital on an ongoing basis, to get staff comfortable with the process. Typically a surveyor will involve new staff during a Tracer; thus signifying the importance of a thorough orientation and training program for your ward/clinic/department.

Be ready to give a tour of your area if necessary during a survey or Tracer. Depending on your area, you may need to have a flashlight.

Make sure your area is compliant with Infection Control, Hospital and Patient Safety, and all National Patient Safety Goals. If you need help in those respective areas, contact Infection Prevention & Control Consultant (6-7821), Fire/Safety Officer (6-7371), and Patient Safety Officer (6-7190).

Examples of questions from recent surveys include but are not limited to:
What are the two patient identifiers? Full Name and Date of Birth
What is the PI project for your area? Every section should have one-ask if you don't know.
What fire zone are you in? Know this. It will be listed on all pull stations, on the ceiling alarms and on your clinic walls and doors.
Do you know about our falls protocol program? MEDDAC Pam 40-41

PATIENT RIGHTS AND ORGANIZATIONAL ETHICS

GOAL: To help improve patient outcomes by respecting each patient's rights and conducting business relationships with patients and the public in an ethical manner.

What are patient rights? Patient rights are those entitlements that a patient can be assured he/she will receive from the health care system and providers. Information regarding Patient Rights and Responsibilities are provided to patients upon admission to the hospital (included in the "Patient Information Guide"). A framed copy of Patient Rights and Responsibilities is also posted in multiple areas throughout the facility. Competent adult patients have a moral and legal right to participate in their medical care and to refuse medical treatment, even in life saving or life sustaining situations. Further information on patient rights and informed consent can be found in MEDDAC REG 40-72 (Patient Rights and Staff Rights and Organization Ethics). Staff is educated on patient rights during hospital orientation. Examples of patient rights are listed below:

- Right to quality medical and dental care, and the right to refuse that care
- Right to considerate and respectful care
- Right to privacy and confidentiality
- Right to know the identity of caregivers
- Right to be informed about their care, and to be provided information in terms they can understand
- Right to receive all information about their care, including alternative treatments, risks, and benefits so they make an informed decision
- Right to be informed if treatment is part of a research project, and the right to refuse to participate in research
- Right to care and treatment in a safe environment
- Right to be informed of rules and regulations that apply to patient and visitor conduct
- Right to pain management
- Right to be effectively informed of sentinel events and adverse outcomes

Who is responsible for assuring that the patient's rights are respected and maintained at all times? It is the responsibility of every EACH employee.

You are demonstrating to the surveyor that you respect the patient's privacy and confidentiality. How is this demonstrated?

- Provide privacy during care, exams, and procedures by closing doors or pulling curtains
- Should also include gowning or draping patients
- Provide the opportunity for a chaperon during an examination, treatment, or procedure that is sensitive or potentially compromising
- Provide privacy during 1-to-1 discussions
- Introduce yourself and state your job title, wear ID badges to assure patients and staff know who you are; including the surveyors, write the name of the RN/LPN or Medic responsible for inpatient care on patient's room board.
- Get patient/family permission before allowing surveyor to interview them
- Knock on door and wait for a response before entering patient's room
- Keep medical record secured
- Log off computer terminal; assure that computer monitor screen is not visible to those who do not have a "need to know"; and do not share access codes. Accommodate patient request for room transfer if medically feasible or available
- Do not discuss patient information in hallways, elevators, the dining facility, or other public areas.
- Ensure forms with patient information are not placed where the public and others can view them.
- Ensure full patient names and/or diagnosis/procedures are not listed on bulletin/ white boards, or clinic sign-in sheets.

How do you identify and resolve ethical issues in patient care? Staff is encouraged to identify, discuss and question ethical dilemmas (care at the end of life, quality of life, organ donation, DNR, etc.). If the concern cannot be resolved with the treatment team and/or patient and family members, the hospital's Ethics Committee is available for consultation to review and provide guidance and recommendations. To access the committee during duty hours, contact the Patient Representative office or the Chaplains Office, and relay the nature of your request. After duty hours, holidays and weekends, staff should contact the AOD, who will notify the DCCS and the Ethics Committee Chairperson.

How do you obtain interpreters or translators in EACH for patients who do not speak English? Translation services for foreign languages are available at no cost and can be arranged through Communications Operator by calling 526-7000 and requesting translation services. Refer to MEDDAC Policy # 87 Language Translation Services Request.

How do you obtain Sign Language Services? You will need to have the following information first: The Patient's Name; Date & Time the Sign Language (SL) Interpreter needs to be at the Hospital; Length of visit; Name of the requesting section; Doctor who will be seeing patient; Location where the SL Interpreter needs to go. If during normal business hours, Monday-Friday, call Martha Heald, Contracting Officer Representative (COR) in Logistics at 526-7617 or 526-7209, who will get everything set up for you. You will be required to complete the paperwork for this service & hand carry or email it to Martha Heald by the next business day. If services are required after normal business hours, on the weekends, or Holidays, the AOD will contact the company at 599-4517, and if necessary contact the company by their emergency pager at 474-7154. After the contact has been made, you will be required to complete the paperwork for this service & either hand carry or email to Martha Heald, COR in Logistics by the next business day.

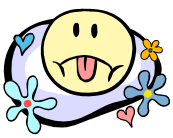
The required service paperwork is located on the Logistics SharePoint Intranet site. Failure of the Government representative requesting the service to contact Ms. Martha L. Heald and submit a payment request could result in a finding that individual is liable for payment of the service. We have a contract in place for this service and in accordance with the contract have to provide 24 hours notice to Sign Language Network for services. However, SLN does provide emergency services if they can locate an interpreter for our needs.

The hospital point of care for patients who have a disability and need auditory materials or phone amplifiers for their phone while in the hospital is the Ward/Unit/Clinic NCOIC through IMD Telecommunications @ 526-7952.

How do you meet the spiritual needs of your patient? Patients have the right to participate in spiritual activities within applicable military regulations as long as it does not interfere with diagnostic procedures or medical treatment. Patients are assessed for any spiritual needs during the initial admission assessment. Chaplains are available 24 hours a day.

How do you know if a patient is happy with his/her care? Customer satisfaction surveys are conducted through a DoD contract system in which all patients receive a personal survey via the mail following their appointment. In addition, patient care areas conduct patient satisfaction surveys through Interactive Customer Evaluation (ICE) cards that are present in each clinic. The Patient Advocate Office reviews all compliments and complaints and reports any trends to the Command and Department Chiefs. A patient can voice concerns/complaints or compliments verbally or in writing to the Patient Advocate Office or by calling 526-7225. The Patient Advocate Office formally recognizes and rewards employees who have gone above and beyond in caring for our patients. Concerns about patient care and safety that have not been addressed by EACH may be forwarded to The Joint Commission. There is a link on the QSD, Joint Commission SharePoint site.

How do you care for the dying and terminally ill patient? Comfort and dignity guide the care of the dying patient. The care focuses on the patient and family in all aspects of care; aggressive and effective pain management, respect for patient values, access to spiritual support and sensitivity towards organ donation and autopsy. Spiritual assessment should be incorporated into the initial and ongoing assessment of all patients, but most especially for the dying or terminally ill patient.



How does EACH ensure patients receive appropriate pain management? Patients are screened and/or assessed for pain in accordance with EACH MEDDAC Reg. 40-21 (Pain Management). Pain management is provided through a variety of pharmacological and non-pharmacological treatment modalities. Patients are provided education regarding pain management in both the inpatient and outpatient settings. Remember that patients have a right to appropriate assessment and management of pain. EACH respects this right. Ask your patient about pain regularly, and certainly following each intervention.

To access the 2011 Joint Commission Standards, please visit, http://e-dition.jcrinc.com/ProxyLogin.aspx?lnk=F13578C20A61 Any staff member can access the Joint Commission CAMH found there.

What are Advance Directives and where can the patient obtain information regarding them? An advance directive is a written statement of the patient's wishes regarding their health care/medical treatment such as life support measures, nourishment procedures and other matters. It is used to guide decisions when and if the patient were suddenly incapacitated or become terminally ill. Three kinds of advance directives recognized in the state of Colorado are as follows: Living Will, Medical Durable Power of Attorney, and CPR (Cardiopulmonary Resuscitation) Directive. Information regarding Advance Directives is provided to all adult patients upon hospital admission. This information is also available in The Patient Information Guide located throughout the hospital. Legal advice is available at the Fort Carson Legal Assistance Office by calling 526-0490/5572.

Ask a staff member, where can I obtain information on Advance Medical Directives & Resuscitation /Do Not Resuscitate Orders (DNR)? EACH MEDDAC REG 40-3-20 covers all of these areas. It includes specific information on the process for documenting patient wishes outlined in an Advance Medical Directive, how patients designated DNR are identified, implementation of advance directives, who can write and sign an abatement order, the process for withdrawal of life-sustaining treatment, etc.

How are DNR patients identified in this facility and how is their DNR status communicated? Patients admitted to EACH whom have a DNR order will wear a purple DNR wristband in addition to their patient identification wristband. This purple tag alerts health care personnel to refer to the patient's medical record for an explanation of the code status. When the patient is transported any place in the facility, the patient's nurse will call ahead to alert the patient's receiving ward or treatment area of the patient's DNR status. If a patient is transferred from one medical care team to another, the transferring physician will alert the receiving physician of the patient's DNR. Writing an order can also serve as communication among providers**.**

What areas are addressed in MEDDAC REG 40-72 (Patient Rights and Organization Ethics)? This regulation addresses several aspects of Patient Rights, and includes 3 Appendixes. The following areas are addressed in this regulation: The Ethics Committee, Staff rights, Organizational rights, Statement of Patient's Rights, Child/Adolescent Rights, and Statement of Patient's Responsibilities.

Is there a requirement to discuss unanticipated outcomes of care with patients and/or patient's family? Yes. This standard is covered in RI 01.02.01. Patients and, when appropriate, their family members are informed about the outcomes of care, including unanticipated outcomes. There are EACH guidelines for disclosing information concerning unanticipated outcomes of care. In the event that the results from treatment or a procedure differs significantly from what was anticipated, the primary physician/caregiver shall communicate said outcome to the patient. At no time shall information be communicated to the patient or surrogate concerning causation, causative factors, or liability until the matter has undergone thorough investigation and review by the Deputy Commander for Clinical Services and Staff Judge Advocate.

What is the appropriate response for a staff member if one suspects or has knowledge of abuse or neglect of a patient and or visitor? If you are concerned for a patient's or visitor's welfare inform your supervisor immediately. Refer to MEDDAC Policy #7 ("Family Advocacy Program and Reporting Child, Spouse, Handicapped and Elder Abuse"). All concerns of suspected abuse or neglect are reported to and addressed by the Social Work/Family Advocacy office at 526-4585. The Social Work/ Family Advocacy group is available 24 hours a day.

Where can a patient go to obtain information about charges for which they will be responsible?

Patients have the right to receive information about charges for which they are responsible for. Information regarding potential cost or financial charges an individual may incur while receiving care may be obtained through the Hospital Treasurer's Office.

INFORMED CONSENTS

Informed consent is a complex process and it is critical that all medical and nursing staff understand this process. Please refer to MEDDAC Regulation 40-3-127 for complete discussion of this process at Evans.

Procedures or treatments that incur minimal or greater than minimal risk require informed consent. In this regulation we have divided procedures or treatments into 3 categories as follows:

1. Procedures that incur less than minimal risk. These do not require written or verbal consent or universal time out. Examples of these include phlebotomy and in and out bladder catheterization. It is still expected that patients will be educated about these procedures before they are performed.

2. Procedures that incur minimal risk. These procedures do not require formal written informed consent signed by a witness. That is, a verbal consent can be given. Also these procedures do not require the formal universal time out documentation done in our OR. A time out still must be done though. A procedure note is required for these procedures. This note must note that verbal consent was given and the time was done. At their discretion a physician or provider may elect to use a formal written signed consent for these procedures. Examples of these procedures include many outpatient procedures such as a skin biopsy or limited laceration repair.

3. Procedures that incur greater than minimal risk. These procedures require formal written consent using our hospital's consent form that has been properly executed and signed by a witness and the patient. Examples of these procedures include all OR procedures, vaginal delivery and sedated procedures. Universal timeout is documented for these procedures as per our hospital policy.

The informed consent policy also discusses consent for photography and there are 3 categories related to this:

1. Photographs or filming used for identification, diagnosis or treatment do not require formal written consent.

2. Photographs or filming used internally in the institution for training or education require only our standard informed consent form.

3. Photographs or filming used externally such as for educational purposes outside the institution requires a separate photography informed consent form.

Finally the informed consent regulation describes in detail what is required on a written informed consent form and who may sign for that. In this section there is also a discussion of what constitutes a minor according to Colorado state statutes. Also discussed here are different circumstances and conditions for which minors may be seen without consent of the parents.

PROVISION OF CARE

GOAL: To assess patient needs, plan of care, treatment and services.

PATIENT ASSESSMENT - MEDDAC REG 40-71

What important areas should be included in the patient's initial inpatient assessment?

Physiological
Spiritual
Psychosocial
Nutritional
Discharge planning needs
Falls
Additional Assessment
Cultural
Social (including potential for abuse)
Educational
Functional
Pain
Medications

What is the timeframe for completion of the inpatient's initial assessment?
The patient's history and physical, nursing assessment and other screening assessments must be completed within 24 hours of admission.

Is there a difference in how we assess different types of patients? Yes. The assessment process for an infant, child, adolescent or elderly person is individualized according to the patient's needs/condition.

What factors trigger a more intensive physical, nutritional, functional and/or psychosocial assessment?

Admission screening criteria
Patient's condition (e.g. pain)
Response to treatment
Treatment patient is seeking
Patient's agreement to treatment
Requirements by law or Regulation

How often are inpatients reassessed? Patients are reassessed every 24 hours or as warranted by change in patient's condition or diagnosis, and to evaluate a patient's response to care.

How are Adult and Child/Adolescent Functional, Educational, Pain and Nutritional Assessments screened in the outpatient clinics? Patients are assessed once a year. This is done on their first routine appointment of the year in their primary care clinic (FP, IM or Peds). This is done with a questionnaire conducted by nursing staff and verified by the provider. This is then documented in ALTHA.

Whose primary responsibility is it to ensure inpatients that may need rehabilitation services receive a functional assessment (which consists of screening and further assessment when warranted) to determine their need for physical therapy, occupational therapy or speech therapy. Admitting/attending physician or RN performing admission assessment.

If a patient has a positive screen for functional assessment on the nursing admission form what actions should be taken? Send a CHCS Functional Assessment consult to the appropriate rehabilitation service Occupational Therapy (OT) or Physical Therapy (PT). The new Interdisciplinary Plan of Care (IDPOC) was approved and requires discipline to review each patient.

What criteria/conditions can be used to guide the physician or RN to generate a consult (inpatient or outpatient) for a functional assessment?

OT: Patient is below their baseline functional level on Activities of Daily Living (ADL's).
PT: Patient is below on their baseline functional level for ambulation/transfers.

What determines when an outpatient consult for a functional assessment should be sent to PT, OT or Speech Therapy? The initial assessment of the provider and staff.

How do you know if a provider is privileged to perform a procedure? Located on the EACH Intranet Site is a listing of all providers and their privileges. It is available at all times for the staff's use. There is also a binder in the credentials office that contains copies, should the computer be down. The AOD has access to this binder after hours.

PAIN MANAGEMENT - MEDDAC REG 40-21

- Screening for Pain is asking patient if they have pain whether or not the patient mentions a pain complaint.
- Pain Assessment is the clinical evaluation of pain complaint.
- Mandatory screening for the presence of pain is required for all inpatient and APV (same day surgery) patients.
- Mandatory screening for pain in the outpatient setting is not required.
- But anytime a patient has a pain complaint it must be assessed. Further evaluation, reassessment, follow-up or referral is done as necessary for the patient's pain.
- Pain Scales used:
  - 0-10 Scale for older children and adults
  - Wong-Baker faces scale, for children and those who may not understand the 0-10 Scale
  - NIPS – Neonatal Infant Pain Scale is used for newborns on the Mother Baby Unit
  - FLACC scale for young children

CLINICAL CARE OF THE PATIENT

What factors do you consider when making patient care assignments?
MEDDAC Regulation 40-71 addresses patient care assignments. Patient care assignments are typically determined by six factors: stability of the patient, complexity of patient, competencies required in technology required for patient care, degree and availability of supervision required by staff assigned, scope of practice, documented staff competencies and other unit specific factors. Additionally, staff licensure/certifications and training are also considered.

How do you plan and implement age-specific care for geriatric population? How have you adjusted the care of this patient (surveyor points to patient/patient record-answer specific to the patient) based on his/her age (i.e. geriatric patient age 65 years or older)? Clinical staff will adjust care based on factors as:

- Changes in anatomy and physiology, mobility, sensory deficits (i.e. hearing or vision impairment), poly-pharmacy and skin integrity.
- Potential actions available for hearing impaired patient
- Notation on treatment/care plan
- Utilization of alternative methods of communication (i.e. written)
- Potential actions available for vision impaired patient
- Notation on treatment/care plan
- Utilization of alternative methods (i.e. large print material, Braille devices such as elevator floor buttons)
- Discuss how you adjusted patient education based on the patient's age
- Discuss how you adjusted the patient's care based on the social and physiological needs
- Discuss how you adjusted discharge planning based on the patient's age. Did he/she need assistance or special arrangements?

What policy outlines the plan for care and management of patients and staff with latex allergy/sensitivity? It is part of the Infection Control Policy. Latex safe products are available when needed.

PATIENT AND FAMILY EDUCATION - MEDDAC REG 350-31

When assessing the education needs of our patients and their families, we should assess what two important aspects:

- Their ability to learn – inclusive of culture and religious practices, emotional barriers and readiness to learn.
- Their learning needs – inclusive of factors above as well as skills/knowledge deficits.

How does the staff integrate information in order to make care decisions for patients?
Diagnosis, nursing assessment, collaborate with the patient/family allow them to make decisions.

DISCHARGE PLANNING

For information concerning discharge planning, please contact the Medical Management Office at 524-5006.

POLICY FOR SEDATION AND ANALGESIA - MEDDAC REG 40-16-1

What clinical areas in EACH perform procedures that require moderate sedation?

Emergency Department	Gastroenterology Endoscopy Suite
Oral Surgery Clinic	Radiology
Pain Clinic	EENT
ICU	

How do you know that nursing personnel are competent to manage patients undergoing sedation/analgesia?

- Nursing personnel must take an online moderate sedation course and pass the exam at the end of the course once every 2 years.
- Must have BLS, ACLS and/or PALS
- Verification of competency maintained in the CAF

How is the competency of physicians established?

- The Chief of Anesthesia and Operative Services will recommend practitioners for credentialing to administer deep sedation.
- Physicians must take an online moderate sedation course and pass the exam at the end of the course once every 2 years
- Physicians must complete a short hands-on, airway management course once every two years taught by anesthesiology
- Credentialed providers may be found on the EACH home page under Medical Clinics – Provider Privileges and the Credentials Office will maintain documentation or training and credentials to provide sedation/analgesia
- Providers must have current BLS and ACLS cards

FAMILY ADVOCACY PROGRAM AND REPORTING CHILD, SPOUSE, HANDICAPP AND ELDER ABUSE – POLICY 7

Policy 7 governs how employees will identify potential victims of abuse. The policy collectively covers: spouse, child, handicapped, and elder abuse/neglect and exploitation.

How do you identify a victim of abuse? Hospital staff members need to know if a patient has been abused as well as the extent and circumstances in order to give the patient appropriate care. The criteria must address physical assault, rape or other sexual molestation, domestic abuse and abuse or neglect of elders and children. Refer to Policy 7 for criteria in identifying possible abuse in a patient.

RESOURCES FOR SEXUAL ASSAULT VICTIMS

FOR ACTIVE DUTY PERSONNEL:
Sexual Assault Response Coordinator (SARC) /Installation Victim Advocate (IVA)
SARC/IVA is the first person to contact for all sexual assaults presenting to the Emergency Room or outlying clinics. She/he serves as the "center of gravity" for Sexual Assault Prevention and Response and is the key to local coordination and implementation of responses to sexual assault. The SARC assigns an IVA to assist individual Soldiers. Reporting may be either restricted or unrestricted as desired by victim after counseling with the SARC or IVA.

Name/Location: Bldg 1526 Family Readiness Bldg
Phone/Pager
Duty hours: 524-0912
After duty hours: Pager 577-3171
POC: On Call IVA

Must be notified for every sexual assault case.

Sexual Assault Care Coordinator (SACC)
OB/GYN Clinic
Phone/Pager: 526-1118/520-8253

Sexual Assault Care Provider (SACP)
OB/GYN Cinic
Phone/Pager: 526-7409/520-8968

CID: Main 526-3991

CSPD (for off-post assaults): 444-7000

FOR NON-ACTIVE DUTY PERSONNEL (DEPENDENTS AND RETIREES):
Each ER will provide medical treatment as needed, Sexual Assault Forensic Exams are performed at Memorial Hospital and victims will be transferred there for such exams. *The Fort Carson SARC and IVA cannot provide services to anyone other than active duty victims of sexual assault*; victim advocacy is assigned at Memorial Hospital for civilians.
The only exception is if an assault occurred within the marriage (husband rapes wife) then it falls under domestic violence and the IVA (NOT SARC) would be notified (577-3171).

MANDATORY: Report to local law enforcement having jurisdiction of location of incident for all non active duty sexual assaults.

RESTRICTED AND UNRESTRICTED REPORTING PROCEDURES

Restricted: Call SARC, limited notification to chain of command. Report as follows: Female/Male and Unit, was assaulted, no names or rank or other identifiable information.

Unrestricted: Call SARC, MP's if assault happened on post, CSPD if off post. Notify CID and Chain of Command for Active Duty.

Refer to MEDDAC Regulation 40-36 with questions.

EMERGENCY RESUSCITATION: CODE BLUE RESPONSE, MEDICATIONS AND EQUIPMENT– MEDDAC REG 40-40 AND POLICY 8- BASIC LIFE SUPPORT CERTIFICATION FOR HOSPITAL PERSONNEL

Who is required to obtain BLS, Heartsaver or ACLS training?

Basic Life Support Healthcare Provider Course (BLS Provider) All health care personnel, military, contract employees and DOD civilians must be proficient in BLS if they provide or have the potential to provide direct patient care either diagnostically or therapeutically. Administrative and clerical personnel are highly recommended to receive the training, but it is not mandated. Health care employees must show proof of current BLS Registration status before starting work.

Heartsaver This course is highly recommended, but not mandatory, for all administrative and clerical personnel (non-healthcare providers) who work in a clinical patient care area (diagnostic or therapeutic) and do or could have direct contact with patients. This includes receptionist and medical clerks in outpatient clinics, medical clerks in inpatient areas and clerical staff in clinical support areas such as pharmacy and laboratory and nutrition care aides.

Advanced Cardiac Life Support (ACLS) ACLS training is recommended for all physicians and nurses in inpatient and outpatient settings. Staff must abide by unit/clinic specific guidelines in achieving and maintaining ACLS Registration. All physicians and nurses working or assigned to critical care areas (Emergency Department, Intensive Care Unit, Recovery Room, etc) are highly encouraged to have updated ACLS training and maintain current Registration as an ACLS provider.

Who is responsible for emergency resuscitation procedures in the clinical patient care areas? All members of the healthcare team have a responsibility in initiating and carrying out emergency resuscitation procedures.

All hospital personnel must be aware of the Code Blue Alert notification procedure. Call *46 and give operator your name, location and nature of event, approximate age of patient (adult or child). Bystanders should initiate BLS as appropriate.

Unit personnel must know the location of the nearest crash cart, bring it to the patient, connect to monitor-defibrillator, apply AED and BLS as needed, and assist Code Team with all resuscitative efforts.

Code Blue Team members respond immediately to the location and perform emergency resuscitative measures IAW ACLS guidelines.

Medical Officer of the Day (MOD) will respond to all code events, take charge and direct the rest of the Code Team in resuscitative efforts during duty hours. The ED physician will take charge and direct the Code Team in resuscitative efforts during non-duty hours.

Code Team Members include: 1) Physician, 2) 2 RNs (ICU & ED), 3) Respiratory Therapy, 4) Pharmacy Representative, 5) Anesthesia support, 6) Pastoral support, 7) Nursing Section Supervisor, 8) Ambulance EMS support. Members 1-3 &8 (if available) respond to all codes. Members 6-7 are not always in house.

How is crash cart integrity maintained and what happens when the seal on the cart is broken? How is a code event documented and what is the review process following a code? Please refer to MEDDAC Reg 40-40 for the most current procedures and information related to crash cart maintenance and required code-related documentation.

What are the training requirements to ensure clinical staff are prepared in emergency resuscitation response?

- Supervisors of each clinical area, inpatient and outpatient, must ensure that all staff participate in at least one mock code annually.
- The mock code should be specific to the patient populations(s) served in that area. If the unit serves adult and pediatric patients, staff should participate in a mock code specific to each.
- Mock code training should be documented on the Mock Code Training Log in Section IV of CAF. The Education department provides Mock Code Train the Trainer classes and can assist with training resources such as manikins, AED's, mock code training format, and names of Mock Code trainers. The Pharmacy has the training crash cart which can be checked out for in-services.
- Each unit is responsible for organizing and conducting their mock code training.
- The Education Department can assist with training resources, such as a training crash cart, mock code training format, names of volunteers trained in ACLS, etc.

How should you provide emergency resuscitation to a pediatric patient or infant in cardiopulmonary arrest?

- Dial *46 and alert the Code Team, specify to the operator that it is a child/infant. The operator will announce this in the overhead page to ensure the Pediatrician on call responds to the code.
- All hospital crash carts carry the essential supplies needed to perform pediatric resuscitation for all ages, infants to adults. Clinical areas serving infants and children have an assigned Broselow Bag with their crash cart. Labor and Delivery and Special Care Nursery have specially stocked Emergency Medical Kits to support newborn resuscitative efforts.
- The Broselow Tape/Bag System allows staff quick and easy access to color coded, weight based supplies and medication dosages specific to the individual infant/child.
- The EACH Pediatric Standardized medication Dosing Guide is a medication reference tool that corresponds to the Broselow system and is located in the Red Resource Book on top of every crash cart. Upon admission the nursing staff will immediately print /copy a Medication Dosing Guide specific to the individual patient as a reference in the event of a code. A copy of the color coded, weight specific dosing guide is placed at the front of the patient's chart and at the foot of the patient's bed/crib.
- Resuscitative measures are directed IAW Pediatric Advanced Life Support (PALS) guidelines. Current PALS training is highly encouraged for all staff serving pediatric populations.
- Education & Training has a training Broselow bag for in-servicing units.

RAPID RESPSONSE SYSTEM: Because every life is priceless.

The Rapid Response team (RRT) is designed to facilitate enhanced assessment of patients at risk of life threatening events by highlighting and responding to clinical triggers such as change in level of consciousness, increased oxygen needs as well as other vital sign criteria that may indicate a deterioration of a Patient's condition. The RRT Registered nurse and Respiratory therapist collaborate with the ward nurse to assess the patient, initiate appropriate treatment, contact the attending physician, implement orders, and transfer to a higher level of care as necessary.

The theory behind the RRT is based on evidence that patients who experienced cardiopulmonary arrest (Code Blue) showed signs and symptoms of deterioration 6-8 hours prior to a code situation. It is also known that fifty percent of the patients who code die during the code and only

ten percent live to discharge. Joint Commission Standard PC.02.01.19 holds health care facilities responsible for "… recogniz[ing] and respond[ing] to changes in a patient's condition." At EACH, we have a RRT that can be activated to help the family centered care team assess a patient's change in status and assist in quickly determining additional interventions. Any concerned person can call and activate the RRT, including a patient's family member, the staff nurse, or other hospital staff.

Currently the only area at EACH that has implemented the RRT is the Family Care Ward. The RRT is activated by calling *46 on any hospital phone, stating "activate RRT", and giving the location of the Patient. The RRT should be used only if the patient is not in eminent danger of cardio-pulmonary failure. When in doubt call a CODE BLUE.

RESTRAINT USE – Policy 56

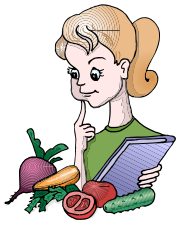
Restraints are only used in an emergency or as a last resort to control a patient's behavior that is unsafe for the patient or staff.

Restraints at Evans can only be used in the ED, ICU or Family Care Ward. Only staff trained in restraint use may care for a patient in restraints. Restraints authorized for use here are either 2 point or 4 point soft extremity with or without a restraint vest. Do not use unauthorized restraints devices.

Physicians and mid-level providers with admitting privileges, ED physicians and ED mid-level providers may order restraints. RNs may initiate restraints in emergency situations.
There are 2 methods of restraint use at Evans. These are behavioral health restraints and medical/ surgical restraints.

Behavioral health restraints are for violent, aggressive or destructive behavior. Typically these patients are very agitated or intoxicated and are ambulatory. A patient in behavioral health restraints requires continuous one-on-one observation and monitoring by trained nursing staff. Security personnel or police officers may be needed during these episodes but are not to substitute for the required nursing personnel for this one-on-one observation.

Medical/surgical restraints are used to promote safe healing. The typical patient requiring medical /surgical restraints is confused and thrashing around in bed but is not ambulatory. Monitoring and assessment of the patient while in restraints is critical to their safety and must be done precisely according to our policy. Orders and documentation for restraints must also be done precisely according to our policy. In the ED approved hard copy documentation forms are used for this. In the ICU and Family Care Ward approved orders and documentation in Essentris are used.



NUTRITIONAL ASSESSMENT OF PATIENTS – MEDDAC REG 30-4 NUTRITIONAL ASSESSMENT OF PATIENTS

How are patients screened and assessed for nutritional risk in the inpatient setting? As per MEDDAC Reg 30-4, the admitting registered nurse will complete section VII: Nutrition Screening by Nursing Staff of the MEDCOM 685-R Initial Assess Form or the Nutrition Risk Assessment on the Pediatric Admit Assessment (MEDCOM) within 24 hours of admission. A diet technician will complete a chart review on all patients within 24 hours of admission. If a patient is considered level 2 (med nutrition risk), the diet tech will visit the patient and complete a further assessment. If the patient is level 3 (high risk), the dietitian will complete an in-depth assessment within 2 days.
For all pediatric patients, the diet tech will visit the patient, parent, and/or guardian and complete a further assessment. If the pediatric patient is determined to be at nutrition risk, they will be referred to the dietitian for further intervention. A physician, nurse or other health care provider

may immediately send a CHCS consult or SF 513 consult request for a dietitian if they perceive the patient to be at high nutritional risk and in need of more immediate assessment by a dietitian.

How are patients reassessed for nutritional needs? Level 1 (low risk) patients are reassessed by diet techs every 5 days. Level 2 patients are reassessed by the diet tech every 3 days and level 3 patients are reassessed by the dietitian every 3 days.

Reassessment is also conducted by the Nutrition Care staff through other mechanisms, i.e. monitoring NPO/clear liquid diet status, modified diet orders, obtaining diet tolerance and tri-weekly discharge planning meetings. Ward staff document changes in patient's condition and may consult Nutrition Care Department (NCD) at any time via Nursing of Physician Consult.

How do you monitor the patient's response to nutrition care? Response to nutrition care/medical nutrition therapy depends on the medical condition, but some considerations include laboratory values, appetite, weight changes, and changes in food intake or tolerance to food. Through daily nursing screenings/assessments, diet technician and dietitian monitoring, as well as physician-patient interactions, patient's nutrition status is monitored.

How does the NCD meet patient's needs for special diets and accommodate altered diet schedules? The physician orders the diet for the patient and the nursing personnel ensure the order is entered on the ward diet roster and provided to NCD. Any changes made to diet orders are immediately faxed to NCD. Therapeutic and regular diets are developed based on guidelines provided by the The American Dietetic Association Manual.

Patients can select their meals from daily menus. The menu for the patient is individualized based upon a patient's food preferences and tolerances, which are obtained by the diet technician, and evaluated for compliance to the diet order. Any altered diet schedule can be accommodated via meals and snacks that are provided throughout the day. Specific cultural and/or religious food needs can be accommodated within the guidelines of the physician's diet order. Every attempt will be made to incorporate all foods into the patient's meal plan.

Does the staff of the inpatient and outpatient psychiatric settings coordinate with the dietitian to ensure the nutritional needs of the patient with emotional and behavioral problems are included in the assessment process? There is not an inpatient psych ward at EACH.
All patients are screened for nutritional concerns by their Primary Care Providers, with the exception of OB/prenatal care. OB/prenatal patients are screened for nutrition risk at their initial OB processing appointment. If needed staff may send a CHCS consult to a dietitian for patients identified with nutrition and counseling needs such as eating disorders and excessive weight loss/gain.

How is nutritional screening and assessment of patients accomplished in the outpatient setting? Patients are screened by their Primary Care Providers using the Annual Adult Questionnaire of Annual Child and Adolescent Questionnaire. The physician or other healthcare provider can refer the patient to the Nutrition Clinic for diet education via CHCS consult.

POINT OF CARE TESTING (POCT) PROGRAM – MEDDAC REG 40-31-2

For more information on Point of Care Testing please contact 526-6226

What sites at EACH perform POCT; waived, moderately complex or provider-performed microscopy (PPM)? EACH POINT OF CARE TESTING SITES (MEDDAC Reg. 40-31-2) Refer to the following chart:

TEST MENU by TEST SITE

Clinic / Ward	Minimally Complex (Waived)								Provider Performed Microscopy and Moderate Complexity Testing						Moderate or High Complexity						
	Whole Blood Glucose (Inform)	Whole Blood Glucose (Adv)	Urine Dipstick	Clinitek Status	Urine HCG	Occult Blood	Rapid Strep A	Cholestec LDX	Fern Test	KOH	Wet Prep	Nitrizine	Urine Microscopic	Serum hCG	RSV	Monospot	Ictotest	Clinitest	Influenza A&B	Gram Stain	PT/ INR
3E L&D	X								X		X	X									
3E MBU	X																				
5E	X																				
Emergency Rm	X	X	X	X	X	X	X														
Acute Care Clinic	X																				
Evans Family Practice Clinic	X		X	X		X	X														
DiRaimondo-South			X	X	X	X	X														
GI Clinic	X				X																
ICU	2																				
Internal Medicine	X		X	X		X	X														
Pediatric Clinic	X		X	X		X	X														
Physical Exams						X															
Recovery Rm	X				X																
Same Day Surgery	X				X																
Dermatology										X											
Urology Clinic			X	X									X								
OB / GYN Clinic									X	X	X	X									
External Clinics																					
DiRaimondo Health Clinic	X		X	X	X	X	X			X	X		X	X		X	X	X		X	
Robinson Health Clinic	X		X	X	X	X	X			X	X		X	X	X	X	X	X	X	X	
Warrior Health Clinic	X		X	X	X	X	X			X	X		X	X		X	X	X		X	
SRC Site								X						X							
STD Clinic										X										X	
Wellness Center								X													
Pueblo Chem Depot		X	X	X																	
Premier Army Health Clinic	X		X	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X	
Coumadin Clinic																					X

What is Point of Care Testing (POCT)? POCT refers to performing lab tests at the point of care or where the patient receives care (inpatient or outpatient). The complexity of the test performed may range from waived to moderate complex. The specimen is obtained, tested, resulted, documented and reviewed where care is provided.

Can anyone perform waived testing at POCT sites? No. Only individuals who have received adequate training and demonstrated competency may perform POCT. Competency is assessed by two of the following: performing a test on an unknown specimen, periodic observation of routine work by the site POCT Supervisor, monitoring each user's quality control, having written testing that is specific to the method assessed.

Why is it necessary to perform Quality Control prior to patient testing? Quality Control is necessary to verify that the equipment, reagents, and test methods employed are functioning within acceptable limits. If controls do not meet established criteria, patient testing cannot be performed.

ARMY SUBSTANCE ABUSE PROGRAM (ASAP) – AR 600-85

How does the hospital assess the specific needs of patients who are receiving treatment for alcoholism or other drug dependencies? Clinicians are to be familiar with referral procedures, including generating electronic consults to ASAP through appropriate channels. In addition, the assessment should be augmented through cooperation between the referring provider and the ASAP clinical staff by providing collateral information needed. This is in compliance with the Army's Substance Abuse Program also known as ASAP. The ASAP comprehensive outpatient rehabilitation treatment program is designed to provide individualized triage, assessment, crisis intervention, individual and group treatment as well as referrals for detoxification, intensive outpatient and inpatient care to assist patients in their recovery from the impact of alcohol and/or substance abuse. After hours, patients may also be evaluated for detoxification by the Emergency Room in consultation with the on-call MH provider.

What is the focus of ASAP as described in AR 600-85? The primary mission of ASAP is to strengthen the overall fitness and effectiveness of the Army's total workforce and to enhance the combat readiness of soldiers. The ASAP is a command program that emphasizes readiness and personal responsibility.

Who is eligible for services in the ASAP? ASAP services at EACH are provided to active duty military personnel only. Personnel can be referred through command, medical, biochemical identification, investigation and/or apprehension and self-referral. Consultation service is available to all inpatients by referrals from physicians or other credentialed healthcare providers. Active Duty will be offered services through ASAP; however, ASAP has formed a partnership with several civilian agencies to provide substance abuse/dependence treatment to AD personnel during times of reduced ASAP manpower or increased referrals.
Family members, retirees and other beneficiaries will be referred to civilian providers off post.

Where is the ASAP administrative office located? ASAP is located at 1636 Elwell Street Building 6236. The hours of operation are Monday – Friday from 0730-1630. Triage hours are Monday – Thursday from 0730 – 1200. Emergencies after duty hours or weekends are referred to the Emergency Department. For additional information you may contact the ASAP Clinic at 526-2862.

MEDICATION MANAGEMENT

GOAL: To provide individualized medication management that is responsive to specific patient needs. To provide care that respects choices, supports our patients' participation in the care provided, and recognizes their right to experience achievement of their personal health goals.

MEDICATION USE:

Is there a policy or regulation regarding medication use at Evans? Yes, MEDDAC Regulation 40-2-114, Medication Management System, governs all activities in our hospital with regard to medication use. You will find this regulation on the Evans web page under Command Publications. This regulation is written in a format which closely follows The Joint Commission (TJC) standards. Most questions regarding the management of medication can be found in this regulation.

How are orders verified and medications identified before being administered to patients? All orders and prescriptions are reviewed by a pharmacist before being dispensed or administered. There are two exceptions to this standard (MM.05.01.01): When a Licensed Independent Practitioner (LIP) controls the entire process: ordering, preparation, administration of the medication and in urgent situations when the resulting delay would harm the patient, to include situations in which the patient experiences a change in clinical status.

To access the 2011 Joint Commission Standards, please visit, http://e-dition.jcrinc.com/ProxyLogin.aspx?lnk=F13578C20A61 Any staff member can access the Joint Commission CAMH found there.

What is an override? When medication is taken from Omnicell or ward stock and the order is not reviewed by a pharmacist before administration to a patient; and, one of the two exceptions spelled out by TJC does not apply, this constitutes an override. In no case is it acceptable to remove medications from Omnicell for convenience of the healthcare professional.
Describe how you monitor the effects of medications on patients. Patients are monitored for the effectiveness of medications by physicians, nurses, and pharmacists. Assessment of the medication's effect on the patient includes the patient's own perceptions, and information from the patient is documented in the medical record. There is an increased sensitivity to monitoring of patients on any of the medications designated as high alert/high risk medication in EACH (MR 40-2-114).

How are medications stored on the unit? All medications, to include non-prescription drugs, are either under direct observation of a health care provider (24/7) or they are secured in medication rooms in locked cabinets or Omnicell point of use systems. Controlled substances are stored in double locked cabinets or Omnicell. All areas maintaining medications are surveyed by pharmacy personnel during periodic staff assistance visits. The purpose of these Pharmacy Staff Assistance Visits is to advise professional staff on proper storage requirements and other medication related issues.

How are emergency medications made available, controlled and kept secure? Emergency medications are continually available in crash carts located throughout the institution. Checks are performed each duty day by ward and clinic personnel to ensure break away locks are not compromised, equipment is functional and batteries are good. A system is in place to ensure the integrity of medications and immediate replacement when necessary. Fully functional carts are ready and available from MDS at all times.

How do you obtain needed medications when the Pharmacy is closed or otherwise not available? The inpatient pharmacy is open and staffed by a pharmacist 24 hours a day, 7 days a week to serve the inpatient population. *Emergency room* prescriptions may be processed in the inpatient pharmacy when the outpatient is closed. If a situation should arise where a LIP dispenses medication; the medications dispensed will be entered into the patient's profile in CHCS. In the event CHCS is not available, a prescription documented on a DD Form 1289 or a copy of the patient treatment form (SF 558 or SF 600) will be placed in an area designated by the Head Nurse. It is the responsibility of the LIP who ordered the medication to perform a final check of medication for correctness and appropriateness prior to dispensing to the patient. Pharmacy staff will enter the information from these documents into CHCS at a later time.

How do you find out what drugs are on the formulary? EACH's medication formulary is available electronically in CHCS. From CHCS press shift 6 then type FIN (formulary inquiry) then type in the drug name. The formulary is also available by using e-Formulary on the hospital web page: http://www.evans.amedd.army.mil/ . Pressing the e-Formulary button will take you to an easy to use formulary service. You can enter the medication for which you need information or you can print out an entire hard copy formulary.

How do you obtain medications not on the formulary? A non-formulary medication is any FDA-approved medication not available on the EACH formulary.

a. Non-formulary medications are not routinely available for dispensing to patients and not normally stocked by the Department of Pharmacy. There may be some stock of a non-formulary medication based on individual prescriber requests for specific patients.
b. For outpatient prescriptions prescribers requesting non-formulary medications for a specific patient are required to submit an electronic new drug request using AHLTA. The process is as follows:

1) Go to the order consults tab in the A/P module
2) Ensure that the provisional diagnosis is highlighted at the top of

the screen. This will ensure that the provisional diagnosis is associated with the pharmacy "prior authorization" order

3) Type "E" in the "refer to" block. This will bring up EACH PHARMACY SPECIAL ORDER

4) Type the following information in the "reason for request" block: medication, strength, therapeutic indication(s), compelling justification, (clinical reason), prescription directions, quantity and refills.

5) Click on submit.

What is an Adverse Drug Reaction and how do we report it? An Adverse Drug Reaction (ADR) is defined at Evans as: "Any response to a drug which is serious, unintended and physically harmful, occurs at doses normally used in man for the prophylaxis, diagnosis or treatment of disease, and is not considered a pharmacologic extension effect of a drug". You may report an ADR by using an E-4106 and sending it through patient safety. ADR(s) may also be reported using the ADR message service at 524-4824 (524-ITCH).

How do you handle medication errors? The person discovering a medication error will promptly report the error through their respective supervisor using the e-4106 (incident report) which can be found on the hospital web page. Errors classified as Type A or "near misses" can be reported using the e-4106 or by simply e-mailing the respective supervisor. It is important to collect all possible information regarding medication errors in order to identify trends and make corrections to the system to prevent the same error from occurring in the future.

What is our policy on multi-dose vials? In all EACH patient care areas, multiple dose medication vials that contain preservatives will be dated with an expiration date 28 days from first entry or labeled with a completed yellow MDV label (preferred) and will be returned to the inpatient pharmacy on that date or sooner if the integrity of the container appears compromised (cloudy, discolored) or otherwise specified by the manufacturer." (USP Chapter 51). VACCINES ARE EXEMPT from the 28-day rule.

What are range orders and PRN orders and how are they interpreted? "As Needed" or PRN orders are orders acted upon based on the occurrence of a specific indication or symptom. As needed (prn) medication orders will contain a dosage range with a fixed time interval and the specific indication, symptom or reason for administration specified. Example: Percocet 1-2 tablets every 4 hours as needed for pain. The dose used and patient response will be clearly documented. (Please refer to MEDDAC Reg 40-2-114, paragraph i., Range Orders). If ordering multiple medications for the same indication the order must direct the sequence of administration or an objective measure for administering one medication over the other.

What is our policy when patients or their family bring in medications? As a rule a "Patients' own medications" will not be administered at EACH. There are two exceptions: 1. The medication ordered by an EACH provider is not on the formulary and there is no suitable alternative available. 2. The time to obtain the non-stocked medication from our wholesaler or local hospital would endanger the patient's health or well being. The specifics concerning this policy may be found on our web site under command publications in MR 40-2-114 at appendix F.

What is our policy on sample medications? Sample medications are prohibited in EACH.

Who has the responsibility to monitor expiration dating in medication storage areas? It is the responsibility of every health care professional in our hospital. Every clinic, ward, etc. should have an SOP concerning this subject and at the very least must have a process in place.

How do I properly dispose of narcotics or a controlled substance? Evans does not stock any controlled substances that are considered corrosive or highly volatile. Therefore, in compliance with Colorado Department of Public Health and Environment (CDPHE) guidance these medications should be managed like nonhazardous solid waste.

a. Injectable controlled substances should be wasted in the largest waste container (trash can) available. Small volumes (10 mLs or less) can be wasted directly in the can. Larger volumes (11 mLs or greater) should first be wasted in an absorbent material (i.e. a chux) and then placed in the trash. To the maximum extent possible the controlled substance should be rendered irreclaimable.

b. All syringes, IV bags, tubing, needles, etc. are managed by standard operating procedures.

RECONCILIATION OF MEDICATION ACROSS THE CONTINUUM OF CARE (ROMACC):

What is (ROMACC)? National Patient Safety Goal #8 states that each hospital must develop a process for documenting a complete list of the patients' current medications upon admission, with patient involvement. This list is continually compared with medications administered in the hospital and updated with each transfer within the hospital. At discharge the list is given to the patient and communicated to the next level of care. Since 2009 we are required to document when changes (corrections, additions, deletions, etc) are made during reconciliation. We are also required now to document that the list was given to the patient or guardian upon discharge or release form the clinic and to the next provider if known.

Why are we doing this ROMACC? This process will ensure that our patient's medications are appropriate when *reconciled* against what they were taking at home versus what was ordered in the hospital and what they need to take when they are discharged from the hospital. This ensures no drug-drug interactions.

Don't we do this already? Yes, and we do a great job. However, this process will be better. This system consolidates multiple listings of medications. It is more accurate and timely.

Why is ROMACC so important to patient care? Because the most frequently occurring type of medical error is *medication error*. The most frequently cited category of root causes for *serious adverse events* is ineffective communication and the most vulnerable parts of a process are the *links between the steps* (Hand-offs). Medication reconciliation addresses all of these issues.

SURVEILLANCE, PREVENTION, AND CONTROL OF INFECTION

Goal: The mission of the Infection Control Program is to identify and reduce the risks of acquiring and transmitting infections in the healthcare facility and outlying clinics through the delivery of quality healthcare.

How do you monitor hand hygiene? By direct observation every month

What surveillance does your facility perform? Hand hygiene, labeling of IV tubing, ventilator associated pneumonia (VAP) Central line blood stream infections (CLABSI) and surgical site infection (SSI).

How do you know that patient care equipment is clean?

- Equipment in patient care rooms (inpatient room or exam) room is cleaned by housekeeping along with the room. The room is then labeled with a blue label stating date and time it was cleaned.
- Stored equipment has a clear plastic bag over it (unless plugged in to an electric outlet) and labeled with a yellow label stating date and time it was cleaned.

How do you report a bloodborne pathogen? Immediately (within 1 hour) report to department supervisor and fill out the accident report forms found in your department. Report to Occupational Health M-F from 0730-1600 in Bldg 2059 and the Emergency Department after hours**.**

Do you have Cidex OPA® in your area?

- **If Yes – How do you monitor it?** We have a log in which we record the required information.
- **What is the soak time for instruments?** 12 minutes

Do you allow artificial nails in your facility? Artificial nails and extenders are not allowed on any employee with "hands on" patient contact; any employee involved with surgical/aseptic procedures, or any employee involved in the processing of Central Material Supply items.

How long can natural nails be? ≤ ¼ "

What is your policy on IV therapy?

- **How often do you change the tubing?** Every 72-96 hours if no symptoms of phlebitis or infection.
- **How often do you check the IV catheter site?** At least once a shift and as needed (Checks should always documented with site, gauge, and appearance.)
- **What is the hang time for a bag of IV fluid? 24** hours per manufacturer's recommendations
- **What needs to be labeled?** Catheter site and IV tubing on every IV started with date, time, and initials.

How do you communicate that a patient with an infectious disease is in your area? Precaution signs and SBAR.

What is your respiratory etiquette policy? Ask all patients presenting with an upper respiratory infection to wear a mask and cough or sneeze into their sleeve. Employees with an upper respiratory infection should stay home or wear a surgical mask full time if they continue to work.

MRSA: What type of precautions do you use for patients with Methicillin Resistant Staphylococcus aureus (MRSA)? Contact precautions.

What is your policy on food and drink in the work area? No food or drink where there is a chance of exposure to bloodborne pathogens (Includes covered food and drinks) where there is a chance of exposure to blood or body fluids.

Do you need to perform hand hygiene if you do not touch a patient but touch the environment around the patient? Yes

What can be stored under a sink? Nothing

Where is your infection control manual located? (MEDDAC Pam 40-5) and for unit specific policy in hard copy; electronic version is on the QSD web page or in the Infection Control folder on the S: drive

How often do you check the temperature on a patient nutrition refrigerator? Daily

How often does it need to be cleaned? Weekly

Who maintains the temperature log in your area, and do you have 12 months of data? Usually this is performed by the NCOIC. Keep only the current log out and all the previous months in a folder that be accessed if necessary.

What is the hospital policy on covered linen carts? One side can be left open if the cart is in a closed clean room such as the clean utility. All 4 sides must be down if located in an open area.

How do you communicate a reportable disease? Call Communicable Disease, 526-7353 or Infection Control, 526-7821.

Where can you find a list of reportable diseases? MEDDAC Pam 40-5, Policies and Procedures for the Prevention of Healthcare Associated Infections.

When do you have to use soap and water to clean your hands? If hands are visibly soiled with blood or body fluids
What is the contact time for the disinfectant you use in your area? This is product specific so please read the label.

How often do toys need to be cleaned? Please refer to MEDDAC Pam 40-5, Section 6-5.

How often are patient curtains cleaned? Patient curtains will be cleaned at least semi-annually and PRN as per housekeeping schedule.

Are foods or drinks allowed in the front desk and nurse's station? No food or drink in areas where BBP exposure is possible including the front desk and nurse's station

Is it mandatory for civilian healthcare workers to receive the flu vaccine? No, but all civilian employees must fill out a declination statement (waiver) if they decline to be vaccinated.

When does a new employee have to have BBP training? Before patient contact

How do you report a possible healthcare associated infection?

- Using the HOT SPOT form located in the Infection Control folder on the S: drive
- Notify the Infection Prevention and Control office at 526-7821 or 524-1144.

Can a Nutrition Care employee take a tray into a room where transmission based precautions are in place? No

How do you communicate a patient has a transmissible infectious disease to other areas of the hospital? Always call ahead

How do you protect yourself from airborne diseases such as measles, mumps, and chickenpox? Natural immunity or immunization with vaccine and respiratory protection such as the N95 mask or a PAPR.

PERFORMANCE IMPROVEMENT

GOAL: The goal of performance improvement is to continuous process improvement in the areas affecting patient access, patient outcomes, and patient and staff satisfaction. Safe and efficient performance of patient care and their support functions significantly improves patient outcomes, decreases the costs to achieve these outcomes, and positively influences the perceptions of our patients and their families about the quality and value of our services.

The PI model used at Evans is: DMAIC

The DMAIC methodology is the foundation used for all performance improvement projects within the organization. Performance Improvement Projects (PIP) at the department and lower level will use all of the phases but not necessarily all of the steps. The five phases and steps for PIP are listed below.

- **D**efine- Project purpose and scope
- **M**easure- Current performance (baseline data and process flow diagram)
- **A**nalyze- The data collected what's and whys
- **I**mprove- Make changes that will improve the process
- **C**ontrol- Collect data that show continued improvement

ORYX and Balance Scorecard Core Measures (Inpatient only): Now that patients may choose their health care program The Joint Commission (TJC) developed standard performance measures for several diagnoses for inpatient care that the patient may use to compare care given in different hospitals. Our ORYX measures are: Venous Thromboembolism (VTE); Perinatal Care (PC); Surgical Care Improvement Project (SCIP) and Children's Asthma Care (CAC).

Surveyors will assess use of these core measures in our performance improvement. ORYX Core Measures are a critical link between accreditation and the outcomes of patient care, treatment, and services. The core measures allow TJC to review data trends and to work with hospitals that use data to improve patient care processes. If an organizations core measures fall below standard for three quarters in a row, development of an improvement plan must take place. Documentation of the change with data collecting provides information of process improvement.

Army Medical Command, (MEDCOM) has added two diagnoses for us to track and will be used for comparative purposes amongst other medical treatment facilities. These are reported on the Balanced Scorecard and are: Acute myocardial infarction (AMI); and Heart failure (HF)

Both ORYX Core Measures and Balanced Scorecard Measures are monitored on a quarterly basis and reported at the Performance Improvement Committee.

Failure Mode Effect Analysis – (FMEA) FMEA is a proactive tool that looks at any high risk process within the organization to identify and prevent process variations (potential process problems) before they occur. The FMEA methodology is collaborative in nature and is conducted by a team. The intended goal of utilizing the FMEA methodology is to reduce or eliminate the need for revisions (corrective actions) in processes after the risk process has been implemented. A FMEA focuses on the process.

Steps in the FMEA process

- Identify the risk process for review and analysis
- Identify risk points
- Identify steps that can be taken to lessen impact of the risk points
- Review the process
- Assign a detection rating for each failure mode (D rating)
- Calculate the risk priority number (RPN) for each effect. The RPN is calculated by multiplying the severity by the frequency by the detection (S X F X D = RPN)
- Prioritize the failure modes for each action
- Take action to eliminate or reduce the high risk failure modes To demonstrate reduced or eliminated failures, calculate the final risk priority number (RPN) as the failure modes are reduced or eliminated (PRNs can be calculated and trended as steps are taken to reduce or eliminate failure modes to assure process is working)

Failure Mode Effect Analysis (FMEA) for EACH

2003 Patient Falls
2004 Medication Overrides
2005 IV Therapies (Infection Rates)
2006 Patient Flow for Continuity of Care
2007 Provider Credentialing Process
2008 DBH Optimization
2009 DBH Optimization continued (High Risk Patients)
2010 SBAR

Root Cause Analysis (RCA) The RCA is another tool to identify where a problem or potential problems are in a process. The difference between a FMEA and a RCA is that the RCA process happens after an incident or problem has occurred. The focus of the RCA is on the patient and identifies what went wrong. It's designed to set in motion a corrective process so that it does not occur in the future.

Performance Improvement Activities Structure

A. Performance Improvement Committee: The Performance Improvement Committee (PIC) provides corporate level guidance and oversight pertaining to the PI structure and activities. The PIC is chaired by the DCHSN and facilitated by the Performance Improvement Officer. Improvements briefed that cross department or division lines may be voted on at the PIC and if passed sent forward to the Executive Committee of the Medical Staff for approval.
B. The PIC is an open meeting where any staff member is welcome. Departments and divisions brief their PI project using the DMAIC format demonstrating progress of the project over time.
C. Sections belonging to a department or division present their PI projects at the department meeting using the same DMAIC format.

LEADERSHIP

GOAL: For the hospital's leaders to use a framework to establish healthcare services that respond to community and patient needs, leadership must be effective in order to provide excellent patient care.

What hospital Regulation outlines the leaders' plans for the Provision of Patient Care? MEDDAC Regulation 40-71, Plan for the Provision of Patient Care Services.

Where can you find the Scope of Service for your department or service? The hospital's scope of service for every department and subordinate service is located in MEDDAC Regulation 40-71. In addition some clinical areas develop a more detailed scope of service and maintain it on the unit. In this case, it is imperative that the medical director, head nurse and NCOIC have reviewed, concurred and communicated the document to all subordinate staff members.

Who are the key leaders at Evans Army Community Hospital?
COL Jimmie O. Keenan, Hospital Commander
COL Sheri L. Ferguson, Deputy Commander for Health Services and Nursing
COL Mark M. Reeves, Deputy Commander for Clinical Services
LTC Timothy O'Haver, Deputy Commander for Administrative Services
CSM Ly Lac, Command Sergeant Major

ENVIRONMENT OF CARE

What is the procedure in the event of a fire?
RACE (if in the active zone)

(applicable in all outlying buildings and the "hot" zone in EACH)
Rescue-rescue anyone in immediate danger.
Alarm-pull fire alarm and dial 911.
Confine-close all doors, windows.
Extinguish/Evacuate- evacuate the active zone and extinguish if safe to do so.

CAROL (if outside the active zone)
(applicable only to EACH)
Close -all doors throughout the area.
Assist -evacuations from active zone as required by policy.
Reassure -patients/visitors.
Observe -area for smoke and/or fire.
Listen -to public address system for additional instructions.

Where are the fire alarm pull stations located in your area? Near the exits and at nurses/reception areas/desks.

What is your department evacuation route in the event of a fire?
RACE: Move patients and staff horizontally first, using the main corridors and move beyond the smoke/fire doors to another zone. Have two routes on the same level. Use vertical movement only if necessary.
What are your responsibilities if a fire alarm is activated in another zone within EACH?
CAROL: Close doors in your work area, prepare to assist with evacuation, and wait for further instructions. (Refer to area/section SOP, as there may be more specific instructions)

How do you report a fire? Pull fire alarm; call 911 and give name, phone number, and specific location; Do not hang up unless told to do so or situation requires immediate evacuation; implement RACE.

How often are fire exit drills conducted in your area? One drill per quarter, per shift (hospital and outlying clinics); admin buildings annually.

How did you learn what to do in the event of a fire? Hospital orientation when hired, annual area-specific training, and unit orientation.

Should there be an electrical power outage, how would you identify receptacles connected to the emergency power? Emergency power outlets are red and have red faceplates. This is only applicable to EACH.

What is the proper way to store oxygen in your area? All cylinders must be secured. If they have a threaded top, a cap must be tightened in place. No gauges on cylinders in storage. All cylinders must have the purity stamp and In Use/Empty/Full tag attached to the throat. Empty and full cylinders must be separated.

What training have you received in hazard communication (HAZCOM)? Area-specific training is given during unit/section orientation and annual training thereafter.

What is your role in safety-risk management? All employees are expected to practice safety in the work place and report any safety hazards to their supervisor. Anyone may contact the Safety Office for suggestions, comments, concerns, etc.

Do you have utility failure procedures in your department? Utility failure procedures are located on the Systems Failure and Basic Staff Response Sheets posted in the work areas.

Do you know how to put in a work order? Contact Hospital Facility Maintenance at 526-7699 or contact DPW if occupying an installation "owned" building.

Does MEDDAC permit smoking? MEDDAC is tobacco free. The only designated smoking/tobacco use area for personnel working in building 7500/7503 is the break/smoke shelter outside the Logistics loading dock (south side of building). Outlying clinics have designated smoking areas. THIS INCLUDES SMOKING AND SMOKELESS TOBACCO USE.

How can you tell if a piece of medical equipment has had preventive maintenance and/or calibration? It will be tagged with a sticker showing the date last PM/Calibration and the next due date. This tag must be checked prior to using medical equipment. If there is a question or concern, contact medical maintenance.

What types of accidents should be reported? All accidents/incidents involving patients, visitors, and/or staff (whether or not an injury occurred) are reported to your supervisor and the Safety Office 526.7371/524.5586. Safety accident forms should be completed when staff injury occurs. An e-4106 should be completed for all incidents.

What hazardous materials do you have in your work area? (Departmental/unit-specific - check the unit chemical inventory located in your MSDS Book) Each employee is required to review and sign the MSDS book annually or as needed (i.e. when changes/updates are made).

What data does a Material Safety Data Sheet (MSDS) supply? Name of substance, chemical hazards, health hazards, physical hazards, first aid measures, manufacturer's information, fire hazards, personal protective equipment needed, and precautions for safe handling, storage, transportation, and disposal.

What do you do in case of a chemical spill in your area? Contact the Safety Office 526-7371, and Environmental Health Office, 526-7922 to report all spills. Small spills should be contained and cleaned up by area/section personnel according to applicable instructions. Large spills (5 gallons or more) are reported via 911 to the Fort Carson HAZMAT Team (Fire Department). For spill cleanup supplies, contact the Environmental Health Office, 526-7922.

How do you activate and use a fire extinguisher?
PASS
Pull the pin
Aim the nozzle at the base of the fire
Squeeze the handle
Sweep from side to side

What is your responsibility under the Safe Medical Devices Act? It is a Federal Requirement to report incidents when it is believed that medical equipment has somehow failed and adversely affected the patient (prolonged treatment, injury, death, etc.)

What actions do you take? Turn off/disengage the equipment, take care of the patient. Lock up the equipment, DO NOT change the settings or throw away disposables. Leave it as it was while in use. As soon as possible, contact the Safety Office 526.7371/524.5586 or AOD if the incident occurs after hours.

What do you do if you receive a bomb threat (Code Black)? Obtain as much information as possible then notify your supervisor and PTMS (S2/3 – Security 526-7655). Contact AOD after hours.

Where is the Emergency shutoff for piped medical gases/oxygen? This is area specific. They are generally found at the nurses' station in inpatient areas, in the corridors inside the OR Suite, and in corridors in all other locations. All need to look and locate them.

What do you do when a medical gas or vacuum alarm sounds? Check if patients need to be put on cylinders/bottles; these are local alarms and facility maintenance must be called at 526-7699.

Where are the eyewash stations located on your unit? Know where they are located. Know how to use them. They may NOT be blocked by equipment or supplies. If they are located over a sink they must have free/clear access, nothing may be kept in the sink.

Where is hospital staff parking located? Staff can park in parking lots B, C, D and H.

What code is called when an infant is abducted and what action do you take? The emergency code is Pink. Each department has specific doors and elevators to guard and search personnel with suspicious objects (See MEDDAC Security Plan, Chapter 6). Check all closets, bathrooms, and empty rooms not occupied by staff.
Can a law enforcement officer go to his or her appointment with their weapon? No, if the law enforcement officer has a personal medical appointment, the officer can either keep the weapon in their vehicle or secure it in a lock box in ED or the security office, room 2527.

Where is your evacuation assembly point (EAP)? The Emergency Operation Plan (EOP), Annex F or the MEDDAC Security Plan, Chapter 14 outlines the location of each departments EAP.

What is your role and responsibility in the event of an actual/ simulated disaster at EACH? Refer to the (EOP) and applicable Annex. A copy of the EOP is located on EACH SharePoint/DCAS/S2_3/shared documents/EOP or in PTMS S3.

Where is the Medical Operations Center (MOC) located? It is located in room 2500 (Commander's Conference Room). The alternate MOC site is in B7506, Medical Company.

What do you do in a MASCAL? Refer to the main section and area-specific section of the Emergency Operations Plan (EOP).

PLEASE REFER TO YOUR BADGE FOR EMERGENCY CONDITIONS & BASIC STAFF RESPONSE (See EOP and Unit Policies for additional details)

MANAGEMENT OF HUMAN RESOURCES

GOAL: To identify and provide the right number of competent staff to meet the needs of patients served by the hospital.

What mandatory education/orientation is required for your staff? All employees in-process through S2/S3 Education/Training Division and are scheduled for Newcomer's Orientation. Newcomer's Orientation provides information related to environment of care issues such as; Fire and Safety, Infection Control, Security, Hazardous Material and the Emergency Management Plan. Also included are a Command Orientation, Customer Service, Patient Safety and Error Reporting, and Performance Improvement. New employees receive orientation to policies related to pain management, HIPPA, Staff Rights, and elder, spouse, child abuse and neglect, plus other key policies. This information is reviewed during the mandatory annual Hospital Education Training via the on-line APEQS training program.

How do you know your staff is competent to perform their duties? (EACH Competency Assessment Program) Staff members complete a Unit Specific Orientation and receive annual competency assessment. Each staff member participates in ongoing in-service education and

other training to increase his or her knowledge of work-related issues. The staff member's supervisor periodically reviews their abilities to carry out job responsibilities, especially when introducing new procedures, techniques, technology, and equipment. Documentation is maintained in the Competency Assessment File (CAF).
What evidence do you have of attendance at in-services and continuing education programs? Attendance at in-services is documented in the CAF and APEQS data base. Copies of Certificates of Training for continuing education are also maintained in the CAF.

Do you have a copy of, or have you seen, your job description? The job description is reviewed with each new employee at the time of hiring and at the beginning of each performance evaluation period. A copy of the job description is maintained in the staff member's CAF.

How are volunteers used in your area? How are they trained? All volunteers enter through the American Red Cross (ARC) Office. Clinical personnel must in process through the Credentials Office to insure verification of credentials. Volunteers attend an ARC orientation and Newcomer's Orientation before they are allowed to work in patient care areas. Volunteers also receive an orientation to the unit or work area, which is identical to that of the regular employee.

How do you know if a staff member is competent to provide care for all populations in your scope of care? Population based (to include age specific) orientation is incorporated in unit specific orientation. Staff completes an initial Competency Based Orientation, which includes assessment of specific populations served on the unit. Population based competency is included as part of the job description and competency evaluation. Each department provides population based in-services that focus on care provided in that department.

What do you do if you need to use a piece of equipment that is unfamiliar to you? Where do you go for information? Orientation to equipment use is part of the unit specific orientation. Head Nurses and NCOICs provide in-service education as new equipment is introduced to the unit. Section Chiefs, section NCOICs and/or the nursing supervisor are available to consult when additional help is needed.

What is the definition of forensic staff, and are forensic staff oriented and educated about patient care responsibilities? Forensic staff usually have no/limited clinical training and experience, but who may be needed to assist in the work area as a guard, etc., for a patient. These may include security personnel, guards, MPs, etc. Forensic staff must be oriented to fire safety, security, emergency procedures, HAZCOM, infection control, patient confidentiality, and clinical seclusion and restraint policy.

What is the requirement to educate staff on contacting The Joint Commission?
"The organization educates its staff that any employee who has concerns about the safety or quality of care provided in the organization may report these concerns to the Joint Commission."

- The organization educates its staff that any employee who has concerns about the safety or quality of care provided in the organization may report these concerns to the Joint Commission.
- The organization further informs its staff that it will take no disciplinary action because an employee reports safety or quality of care concerns to the Joint Commission.
- The organization demonstrates this commitment by taking no retaliation disciplinary action against employees when they do report safety or quality of care concerns to the Joint Commission.

EACH has developed the following processes to comply with this requirement:
Educate staff on this requirement during the monthly Newcomers Orientation, staff handbooks, and department specific presentations.

What is staffing effectiveness? What are the Clinical and HR Indicators? Staffing effectiveness is defined by the number, competency, and skill mix of staff in relation to the

provision of needed care, treatment, and services.

MEDICAL STAFF

GOAL The organized medical staff plays a critical role in overseeing quality of care, treatment, and services delivered by credentialed and privileged practitioners; it has a key responsibility in delineating the scope of privileged practitioners and evaluating their competency. As well, the medical staff provides leadership in performance improvement activities within the organization.

The Commander, USA MEDDAC Fort Carson is responsible for all medical staff functions. The Deputy Commander for Clinical Services has direct leadership of medical staff functions. Department chiefs and chiefs of clinical departments ensure that medical staff functions are followed within their respective departments.

EXECUTIVE COMMITTEE OF THE MEDICAL STAFF (ECMS) The Executive Committee of the Medical Staff is the decision making body of the Medical Staff and it is responsible for making recommendations directly to the Hospital Executive Committee. The Deputy Commander for Clinical Services serves as chairperson of the ECMS. Other members include physicians, other medical staff members, nursing and other leaders in our hospital.

PROFESSIONAL CARE All members of the medical staff, and all others granted clinical privileges will abide by Federal, State, Army, MEDCOM and MEDDAC policies and regulations including the medical staff bylaws, and all other guidance from external agencies governing the practice of medical care. They will provide adequate professional care within these standards as well as community standards and standards of their profession and specialty within the scope of their privileges at EACH.

PHYSICIAN AND PRACTITIONER HEALTH Physicians and practitioners with a potentially impairing condition due a physical, psychiatric or emotional illness are identified and treated in a confidential and non-disciplinary manner IAW AR 40-68 Clinical Quality Management.

MEDICAL STAFF BYLAWS The purpose of the medical staff bylaws is to establish and direct the professional activities of the USA MEDDAC Fort Carson, CO, Medical Staff. The bylaws prescribe the purpose, structure, composition, privileges, responsibilities, and rules by which the medical staff members perform professional activities. All medical staff members read and agree to abide by the medical staff bylaws. The complete version is available on the Evans Website under Command Publications. Look for MEDDAC Regulation 40-9 Medical Staff By Laws.

INFORMATION MANAGEMENT

Information Management Division (IMD) has a written Information Management Plan (IMP) that outlines its business processes. It identifies its mission, customer, services, the systems we support, etc.

CONFIDENTIALITY AND SECURITY
IMD has a written Information Assurance (IA) policy that outlines its security strategy. IMD is responsible for ensuring that all Information Technology system data are secure. It is mandated that all US Army MTFs follow specific guidelines regarding IA, physical security, confidentially, information privacy, and HIPAA compliance. EACH employs a HIPAA officer, Freedom of Information Act (FOIA) Officer, Information Security Officer (IASO), and Information Assurance Manager (IAM) to ensure it remains compliant with applicable regulations, directives and law.

Part of the IMP is the Continuity of Operations Plan (COOP). This plan ensures that if an IT system failure occurs, EACH staff will have the ability to continue operating in a degraded or manual mode. A COOP has two parts:

1) A viable plan of action and
2) Education and training of staff.

The DoD Information Assurance Certification and Accreditation Process (DIACAP) is another important part of the IMP. This formalized process (or plan) depicts all EACH IT/IS networks, systems and software, their vulnerabilities, and the risks associated with such systems/vulnerabilities. It allows for risk mitigation and/or acceptance.

Q: You are demonstrating to the surveyor that you respect the patient's privacy and confidentiality. How is this demonstrated?
A: "Ensure that your encryption is turned on and that you are using it during any E-Mail transmission of Protected Health Information (PHI) or Personally Identifiable Information (PII)."

"Make sure you remove your CAC card from your computer. Bottom line- if you leave your computer, take your CAC card with you!"

CORRESPONDENCE –RELEASE OF INFORMATION
Protected Health Information (PHI) can only be released by the Correspondence Division IAW AR 40-66, Chap 2-2e. The only exception to this rule is in Policy 93 where it states the provider may print out the encounter and provide it to the patient, after the patient has signed a DD 2870 Request for Release of Information form. Correspondence hours of business are M-F 0730-1630, closed on Thursday afternoons 1230-1630 except for WTU soldiers. Correspondence is located in the SFCC building on the first floor.

INFORMATION MANAGEMENT PROCESSES
These processes are outlined in the Information Management Plan (IMP). Furthermore, a standardized list of unacceptable abbreviations has been distributed in the form of an official “Do not use list” to all sections.

INFORMATION-BASED DECISION MAKING
Clinical decision making of the provider is optimized by the Electronic Medical Record (EMR) by having information that is timely, accessible and legible. Features in AHLTA that support clinical decision making include: standardized order sets, disease based templates imbedded with clinical practice guidelines, ticklers such as wellness reminders and provider alerts (i.e. laboratory/radiology results to be reviewed and orders to be signed). The ability to trend vital signs assists both provider and patient in evaluating clinical progress or lack thereof.

Sharing individualized clinical data with patients is a popular method used to partner with patients and to empower patients in their own clinical decision making. Additionally mailing patients reminder letters regarding preventive screenings due and use of audio call system helps to influence patient decision making.

Aggregate clinical data reports also assists with strategic planning by the Command Group. A variety of performance reports are generated from data extrapolated from electronic records and clinical data bases. For example Medical Management reports information on population health trends, utilization of healthcare services, and performance on clinical practice guidelines. Opportunities for quality improvement and cost containment come from these reports.

KNOWLEDGE-BASED INFORMATION
The Medical Library has access to Knowledge Based Information (KBI) resources for EACH staff, active duty personnel, patients, family members, retirees and eligible beneficiaries.

KBI resources are provided for acquiring and maintaining knowledge and skills needed to improve staff competence, assist with clinical/service and management decision making, provide appropriate information and education to patients and families, support performance improvement and patient safety activities and support the institution's educational and research needs.

KBI resources consist of medical databases, journals, current books, practice guidelines, clinical trials and other resources. KBI resources are available on site, and can be accessed electronically, in print, Internet or audio/DVD. After hour access to KBI is available through the AOD. KBI resources in print will provide the staff with information needed when electronic systems are unavailable.

PATIENT SPECIFIC INFORMATION

What documentation is required for an inpatient record?

The Admission Note will record briefly the clinical circumstances that brought the patient to the hospital, will summarize the proposed diagnostic workup, and will suggest the type of therapeutic management. For surgical patients, the admission note may serve as a preoperative note. This note will also justify the surgery and state the procedure proposed. When the dictated operative report is not place in the record immediately after surgery, a progress note is entered immediately.

A concise Narrative/ Discharge Summary must include the following: Reason for hospitalization, significant findings, and procedures performed and care, treatment provided patient condition at discharge and patient discharge instructions. Discharge summary must be dictated within 4 days of discharge.

A History and Physical (H&P) is completed within 24 hours of inpatient admission and authenticated, dated and timed. The H&P must include the following documentation: Chief complaint, History of Present Illness, Pertinent past medical, social, family history to include use of alcohol and tobacco, pertinent review of systems, physical exam of the heart and lungs, and of affected body part or organ, List of current Medications, Allergies, Impression and Plan.

An Operative Report dictated or written immediately after procedure and authenticated dated and timed. An Operative report must include the name of the licensed independent practitioner and assistants, procedure performed and description of the procedure, findings, estimated blood loss, specimens remove, and postoperative diagnosis.

Post-Operative notes are documented immediately after the procedure and/or administration of moderate sedation or anesthesia and dated and timed. Post-operative documentation must include records of the patient's vital signs and level of consciousness; medications, (including intravenous fluids) and blood and blood components administered: unusual events or complications, including blood transfusion reactions; and the management of those events. This note will record the condition of the surgical wound, indication of infection, and the removal of sutures and drains.

The Final Progress note (SF 509) will record the patient's general condition on discharge, the final diagnosis, and post discharge care, including activity permitted, diet, medications, dressing, and the date and clinic for follow-up care or other actions recommended addressing concerns identified during this hospitalization.

Informed consent signed, dated and timed by all responsible parties within 30 days of the procedure.

All hand written entries are legible

Only authorized abbreviations are used in the chart.

All entries must be signed, dated and timed or electronically authenticated and timed.
Dates will be written day, month, year with month stated by name.

Verbal/Telephone order is dated and identifies the names of individuals who gave, received and implemented the order. Verbal order is authenticated within 24 hours.

Procedures Requiring Informed Consent

- All surgery and other procedures incurring minimal risk or greater than minimal risk that involve entry into the bodily by an incision or through one of the natural body openings, including labor and delivery
- Any procedure or course of treatment in which anesthesia is used, whether or not entry into the body is involved
- Any non-operative procedure that involves minimal risk or more than minimal risk of harm to the patient or that involves a risk of change in body structure
- All procedures in which any form of radiation or other radioactive substance is used in the patient's treatment
- Dental procedures performed that involves the use of general anesthesia, intravenous sedation or nitrous oxide sedation
- All other procedures that in the opinion of attending physician, provider or dentist, chief of service, department or Commander require informed consent
- Photography, filming or recording other than for identification, diagnosis or treatment of the patient

For a list of the following documentation requirements regarding the informed consent, MEDDAC Reg 40-3-127, Informed Consent:

- Content and Documentation of Signed Informed Consent for Procedures Incurring More than Minimal Risk
- Content and Documentation of Unsigned Informed Consent for Procedures Incurring Minimal Risk
- Procedures list Incurring Less Than Minimal Risk

2011 National Patient Safety Goals (NPSG)

Goal 1- Improve the accuracy of patient identification. Team STEPPS, MEDDAC Reg. 40-41. Wrong-patient errors can occur in virtually all stages of patient/provider interaction. The intent of this goal is to verify the person is the correct person for whom the service or treatment is intent and match the service or treatment to that individual. The two patient identifiers can include but is not limited to, the patient's name, date of birth, telephone number or last four of their social security number. The patient's room number or physical location is not an acceptable identifier.

At EACH, the two identifiers used are the patient's last name and date of birth. When should this happen at every patient- provider encounter when providing care, treatment and service.

- All providers must use at least two patient identifiers when administering medication, blood or blood components.
- When collecting blood samples and or any other specimens for clinical testing.
- When providing treatments or procedures.
- Label containers used for blood and other specimens in the presence of the patients.
- Before any blood or blood components are used- use qualified two-person bedside verification.

Goal 2- Improve the effectiveness of communication among caregivers. SBAR, Team STEPPS, MEDDAC Reg. 40-41.

- Write down and read back critical test results to verify accuracy.
- Document that these orders or results were "read back".
- Report critical tests and critical results promptly to the responsible, licensed provider/caregiver.

Goal 3- Improve the safety of using medications. MEDDAC Reg. 40-2-114.

- Label all medications, medication containers and other solution on and off the sterile field in perioperative and other procedural setting. Medication containers include syringes, medicine cups and basins.
- Immediately discard any medication or solution found unlabeled.
- Reduce the risk of patient harm with the use of anticoagulant therapy. This includes the two patient identifiers, base line tests as well as patient/family education. MEDDAC Reg. 40-67-389

Goal 7-Reduce the risk of health care-associated Infections- EACH follows-MEDDAC Reg. 40-41 & MEDDAC Pam 40-05.

- Hand washing is the use of soap and water or alcohol-based rub is required by all staff before, after patient contact and after contact with the immediate patient care environment.
- Using the Patient Safety Reporting e4106 incident reporting system to report any healthcare-associated infections as well Infection Control. This includes missed precautions, cultures and any other infection control concerns or issues related to patient.
- Prevent multi-drug resistant organism infections including MRSA, VRE and C.Difficile.
- Prevent central line associated bloodstream infections.
- Prevent surgical site infections.

Goal 8. Accurately and completely reconcile medication across the continuum of care.
TeamSTEPPS, 2010-2011 PI project, MEDDAC Cir 40-2-114. Patient are at a higher risk for harm from adverse drug events, therefore when communication about medication to patients, review all prescriptive medication, over the counter medication, herbal and home remedies the patient uses. Also note any and all allergies to food, medication including contrast. Note any over the counter, herbal and home remedies in the patient's records as well as reviewed medications with patients across the continuum of care.

- Compare current medication with newly ordered medication, reconcile discrepancies and document in record.
- Communicate medication to the next provider and level of care both in-patient and out-patient's records.
- Proved and explain the current reconciled medication list to the patient and or family.

Goal 15. The hospital identifies safety risks inherent in its patient population. MEDDAC REG. 40-41

- The organizations identifies patient at risk for suicide and refer immediately if necessary. During duty hours at EACH any patient exhibiting SI/HI ideations is immediately referred to Department of Behavioral Health (DBH) as an urgent case. If occurring on the ward, the attending provider will assess and refer as necessary. These patients will be seen immediately by DBH. After duty hours the ED, will

assess and refer the patient to the appropriate network care level of if on the award, the MOD will assess and refer as appropriate.

UNIVERSAL POTOCOL. (UP) Prevention of wrong person, wrong site and wrong surgeries and procedures. MEDCOM Reg. 40-54. MED COM Form 741 & 741-1.

- Conduct a pre-procedure verification process by reviewing documentation, relevant images and need for special implants or equipment. Verify correct patient, correct site and correct procedure and document.
- Mark procedural site unless they qualify with an exception.
- Perform a TIME-OUT immediately before starting the procedure and document.

Culture of Safety/Just Culture. Is a culture of safety and quality, all individuals are focused on maintaining excellence in performance. They accept the safety and quality of patient care, treatment, and services as personal responsibilities and work together to minimize any harm that might result from unsafe or poor quality of care, treatment, and services. Leaders create this culture by demonstrating their commitment to safety and quality and by taking actions to achieve the desired state. In a culture of this kind, one finds teamwork, open discussions of concerns about safety and quality, and the encouragement of and reward for internal and external reporting of safety and quality issues. Culture of safety is a Just Culture, openness and fairness must be present to facilitate effective and honest reporting within safe systems. While there are ample reasons why someone who makes an error might not come forward or report his or her participation in an event, a Just Culture strikes a balance, being neither "highly punitive" nor "blame free." A Just Culture accepts that people make mistakes, but it also facilitates the differentiation and management of behavioral choices so that we improve our chances of achieving the outcomes we desire. Rather than just assume that a bad outcome has a bad person associated with it, we focus on the differences between human error, *at-risk behavior*, and *reckless behavior*—and administer justice based on the quality of the person's choice. The hospital demonstrates this through a proactive, non-punitive culture that is monitored and sustained by related reporting systems (PSR, e4106 patient incidents reports) and improvement initiatives.

"A Just Culture fosters an environment where employees hunger for knowledge and eagerly seek to understand risk."

What is a Near Miss? An event or situation could have resulted in harm to a patient- but did not. The event or situation did not reach the patient because of a change or timely intervention. Examples are, labeling a specimen with the wrong patient information but it was corrected before the specimen was taken to the lab. Nearly giving a wrong medication but after performing the five rights of medication administration the patient did not receive the medication. These near misses can be an important to report as an occurrence or an incident. Do not hesitate to report an error that almost was a sentinel event. The use of the Patient Safety Reporting (PSR) e4106 on the EACH homepage is your opportunity to report any unusually occurrence or incident to be address.

Clinical Quick Links

»AHLTA/CHCS/Essentris	»LEXI-COMP(Drug/Patient Information)
»CME Website	»LEXI-COMP Help
»**Patient Safety Reporting (e4106)**	»Musculoskeletal Treatment Guidelines

Evans Army Community Hospital's "Code of Conduct"

Evans Army Community Hospital is committed to fostering a professional work environment in

which all individuals within its facilities are treated courteously, respectfully, and with dignity. The purpose of the Code of Conduct is to ensure optimum patient care by promoting a safe, cooperative and professional health care environment; and, to prevent or eliminate, to the extent possible, conduct that disrupts the operation of Evans Army Community Hospital, or interferes with an individual's ability to practice competently. To report the matter, staff members will use the e-4106, patient safety reporting- Report of Unusual Occurrence form. Patients who aren't staff members of EACH will use the Disruptive Behavior Incident Report Form. Patients may drop off the form in the Patient Advocate Office. Please refer to the Code of Conduct binder located in your area for further information.

Evans Army Community Hospital (EACH) is Stepping up to TeamSTEPPS!
What is TeamSTEPPS? It is a teamwork system designed for health care professionals that is:

- A powerful solution to improving patient safety within your organization.
- An evidence-based teamwork system to improve communication and teamwork skills among health care professionals.
- A source for ready-to-use materials and a training curriculum to successfully integrate teamwork principles into all areas of your health care system.
- Scientifically rooted in more than 20 years of research and lessons from the application of teamwork principles.
- Developed by Department of Defense's Patient Safety Program in collaboration with the Agency for Healthcare Research and Quality.

Evans Army Community Hospital is committed to providing the highest quality of care and safety to our patients. Western Regional Command is committed to this endeavor for each of it MTFs. Major General Patricia D. Horoho is a proponent for TeamSTEPPS. TeamSTEPPS is for EACH of us at every level.

OTHER HOSPITAL SERVICES

PATIENT- and FAMILY-CENTERED CARE (PFCC)
The PFCC initiative is committed to strengthening the partnership between our providers, patients, soldiers, and their family members. We implement changes to better serve our patients & families by ensuring the family's perspective is considered when developing policies & programs, as well as the delivery of care.

"Patient and family advisors have knowledge we don't have…It is so humbling to realize that patients and families know more about the hospital than you do." Pat Sodomka, former hospital administrator

To become an Advisor or to get information please contact us at (719) 526-7733 or visit us at the Family-Centered Care Resource Center within Evans Army Community Hospital (EACH) in Room 1025.

PATIENT AND FAMILY ADVISORY COUNCIL
While in the hospital, did you ever think of things that we could have done better or differently? Do you have ideas to share concerning ways to make sure other patients and families have the best care experience possible? If so, then being a patient or family advisor might be right for you! Patients, soldiers, and family members who receive care at EACH are eligible to become advisors. Generally, your experience as a patient or family member is the most important qualification. Sometimes we call a group of patients and family members to get feedback about ways to improve our services. Patient and family advisors help us by giving input and feedback to improve the ways that we serve you. We may ask the Advisory Council to share experiences of being in the hospital with our health care professionals and other staff members. For example, you may be asked to tell your story during a training session for hospital staff. By sharing your

experiences and ideas with us, patients and family advisors have the unique opportunity to help improve the care experiences for others.

FAMILY CENTERED CARE RESOURCE CENTER

The Resource Center makes health-related information readily available to patients and their families. This is an empowering service which allows the health care professionals more specialized time with the patients. Compassionate providers understand that patients and their families want to know more about the conditions they face and how to manage them. This Center assists with providing cost-efficient, quality health care by redefining the relationships among providers, patients and their support teams. It offers high quality, individualized health information to the patients, families, staff, and community members. Patients can educate themselves about their best choices; which in turn, equips them to actively participate in their own health care. Visitors will find free materials, computers with internet access available for on-line searches, reference and/or lending library services, a television, VCRs/DVDs for viewing educational material, photocopying, and faxing. A variety of books on child development, parenting, specific diseases, illnesses, grief and loss, nutrition, safety, holistic care and self-help issues are available. Information is offered on local, regional and national organizations to link community services to patients and families. The Resource Center offers a pleasant, quiet space to wait, and relax. The Resource Center is open Monday – Friday, 8:00 a.m. – 3:00 p.m.; depending on volunteer and staff availability. It is centrally located in Room 1025 across from the Coffee Shop and near the chapel.

BEHAVIORAL HEALTH SERVICES

The Department of Behavioral Health (DBH) consists of four services: Psychiatry, Psychology, Community Behavioral Health, and Social Work Services/Family Advocacy Program. The mission of the DBH is to provide quality behavioral health services to the community served by Evans Army Community Hospital (EACH). This includes assessment and treatment services for active duty service members during normal duty hours; 0730 to 1700, Monday-Friday. Patients experiencing after-hours behavioral health crises are evaluated through the EACH Emergency Department. DBH offers individual, marriage, family and group therapies along with an Intensive Outpatient Program. Call 526-7155 for additional information as necessary. **The Suicide Prevention Hotline Number is 1-800-273-TALK.** Access to Behavioral Health Services: The principal focus and mission of EACH's Department of Behavioral Health is to serve active duty personnel. Other beneficiary categories are serviced through the local network and NO Referrals are needed for the first 8 visits per fiscal year with the following types of providers who have a TRICARE participation agreement: Psychiatrist, Clinical Psychologist, Certified Psychiatric Nurse Specialist, Clinical Social Worker, and/or a Certified Marriage & Family Therapist. To find a participating provider, go to www.triwest.com , click "Provider", then "Specialty Behavioral Health" and then select a provider. Military Active duty personnel **must** always have a referral from their Primary Care Manager or DBH provider in order to receive treatment by a Network Provider. OneSource offers short-term, non-medical counseling options to active-duty, Guard, and Reserve members and their families. Each eligible service member or family member may receive up to 12 sessions, per issue, per counselor at no cost.

PATIENT ADVOCATE OFFICE

The Patient Advocate Office offers the following services: wheelchairs while visiting the hospital; pharmacy stickers on ID's for hearing impaired patients; authorizations to pick up medications; referral tracking only; acting as Debt Collection Assistance Officers (DCAO's) to assist with debt collection due to unpaid medical bills; hospital complaints, concerns, and resolution; appointment coordination and beneficiary counseling for the following patient categories: TRICARE, TRICARE for Life, TRICARE Reserve Select, Transitional Assistance Medical Program and MEDICARE patients; deployment and reintegration benefit briefings to Soldiers (Active Duty and National Guard,) and retirees and their families. Customer Service Training for staff members and clinics. This office can provide general information about all hospital activities and assists with meeting all

patient needs as required

INFORMATION CENTER

The Information Desk is the first point of contact for patients, families, and visitors to Evans Army Community Hospital. Many families and visitors are overwhelmed by stress related to their medical condition, worries about being away from work or home or even the fear of an unknown environment. Our job is to effectively support them by providing a warm welcome and efficiently directing them to where they want/need to go. We also assist and support the hospital staff as they work to provide excellent, compassionate care, effective communication, and a secure environment for patients and families. We partner with our community by providing resources and maps that are most beneficial for support and way-finding for those who utilize our services.

WARRIOR TRANSITION UNIT

In the summer of 2007, the Army Medical Action Plan was created to help develop solutions to improve processes and procedures for providing care to ill and injured Soldiers at Army and VA medical treatment facilities. At the heart of the WTU, and the system's success, is it's "triad of care." The triad is comprised of a squad leader, nurse case manager, and a primary care physician. The primary care physician oversees care, which can be complex, given the multiple issues experienced by some Soldiers. The triad of care creates the familiar environment of a military unit and surrounds the Soldier and Family with comprehensive care and support, all focused on the wounded warrior's sole mission to heal and transition. These professionals put the Soldier first, cut through the red tape and mind the details. The Headquarters of the Warrior Transition Battalion on Fort Carson is located at 5889 Barkley Avenue (Building 1161). Primary contact numbers for the WTU are: WTU Battalion Commander, 526-9799; and the WTU Ombudsman, 352-6927. The WTU Ombudsman hotline is 524-0988.

DEPLOYMENT HEALTH

The Department of Deployment Health (DDH) consists of Audiology, Behavioral Health (BH), Traumatic Brain Injury (TBI), Dental, Immunizations, Laboratory, Provider, Optometry, Medical Start and Final, and Automated Neuropsychological Assessment Metrics (ANAM). We process all issues related to Deployment Cycle Support. Pre and Post Health Assessments, DD2795 and DD2796 respectively, are done as an integral part of Soldier Readiness Processing (SRP), within 60 to 90 days immediately prior to deployment and within seven days post deployment. Post Deployment Health Reassessments (PDHRA), DD2900, is completed 90 to 180 days post deployment. The Periodic Health Assessment (PHA), health maintenance and fitness for duty assessment is evaluated every time a Soldier process through the facility. All In-Processing and Out-Processing Soldiers are required to process through the DDH. All processes have been expanded to have the capacity for comprehensive evaluations in BH, TBI, hearing, vision, prevention, risk, and wellness. All processes are multidisciplinary involving the assessment of physical and mental well being in a One Stop Occupational Health Clinic and take place within building 1042. Please feel free to contact us at 719-524-5593, Medical Operations Assistant or 719-524-5591, Office Automation Assistant.

EMPLOYEE ASSISTANCE PROGRAM

- To help employees in identifying and resolving personal problems that may affect their job performance and well-being.
- To assist management in addressing productivity issues.
- To promote installation work/life/wellness programs.
- The EAP program helps employees and their family members with problems that may affect their well-being and their ability to do their job.
- EAP works to help resolve a wide variety of problems including alcohol and drug abuse, work and family pressures, legal and financial problems, job stress, and other concerns which can affect the work performance and personal health.

- Your EAP is located in BLDG 1217 Room 211, for an appointment call 526-8403

IMPAIRED HEALTH CARE PERSONNEL PROGRAM

Health status—to include the physical and emotional well-being of individuals providing care and other services patients—is an important consideration in the ongoing assessment of professional competence and performance. Evans Army Community Hospital has an established Impaired Health Care Personnel Program (IHCPP), to address the multidisciplinary needs of its military and civilian healthcare personnel with physical limitations, emotional or psychiatric conditions, or alcohol/other drug abuse problems/dependency. The IHCPP is designed to provide support, assistance, and rehabilitation to those healthcare personnel who suffer from a condition that negatively influences, or has the potential to negatively influence, optimal performance. All healthcare personnel (military and civilian) known or suspected of having an alcohol/other drug abuse/dependence problem will be reported, or may self-report, to the Impaired Health Care Personnel Committee. For more information please refer to MEDDAC Regulation 40-8 or contact 526-7366.

Care Provider Support Program (CPSP)

Provider fatigue (Compassion fatigue/secondary Trauma Stress) and burnout among Care Providers are readiness issues. This AMEDD mandated program covers the topics of compassion fatigue, burnout and how to stay resilient through the development of a self-care plan. Care providers are defined as: all personnel (Officer, Enlisted and Civilian) in direct patient care. (Clinician; including dentists and Veterinarians, Direct Care Professionals, Registered Nurses, Direct care paraprofessionals) All other staff members are highly encouraged to participate in this program.

The sustainment training for care providers consists of completing the AMEDD Care Provider Support Program survey at https://www.us.army.mil/suite/page200013 and attending the CPSP annual classroom training.

Additional resources and help is available through this program (i.e. counselor, fitness, ACS, spiritual etc…).

POC: Angela McGrady, Care Provider Support Program Instructor Trainer, 719-526-7560

MEDDAC Regulations and Policies can be found on the EACH SharePoint Home Page http://amedapeach054/default.aspx under Command Publications.

The Joint Commission SharePoint site can be found under DCHN, QSD, Joint Commission http://amedapeach054/dccs/qsd/jc/default.aspx

To access the 2011 Joint Commission Standards, please visit, http://e-dition.jcrinc.com/ProxyLogin.aspx?lnk=F13578C20A61 Any staff member can access the Joint Commission CAMH found there.